

# **S.C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS**

## **Individual and Family Support - Request for Payment**

### **SECTION A: PAYEE INFORMATION**

Payee: \_\_\_\_\_

Address: \_\_\_\_\_

### **SECTION C: APPLICANT INFORMATION**

Applicant's Name: \_\_\_\_\_

Applicant's SS#: \_\_\_\_\_

Description of Service: \_\_\_\_\_

### **SECTION D: AUTHORIZATION**

I hereby certify that all information is true and applicable.

\_\_\_\_\_  
Signature of Executive Director/Designee

\_\_\_\_\_  
Date

### **SECTION B: PAYMENT INFORMATION**

Payment Month: \_\_\_\_\_

Payment Amount: \$ \_\_\_\_\_

Check one:

\_\_\_\_\_ One-Time Payment

\_\_\_\_\_ Monthly Payment (PO Required)

Purchase Order Number: \_\_\_\_\_

Vendor Number: \_\_\_\_\_

\*When payments for the calendar year total \$600 or more and are made directly to a provider of service operating under a social security number, a 1099 statement will be issued to the provider of service for tax reporting purposes.